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7  
8 **BEFORE THE**  
**BOARD OF REGISTERED NURSING**  
9 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

10 In the Matter of the Accusation Against:

Case No. **2010- 623**

11 **DEBORAH ANNE BENNER**  
12 **10827 Sierra Mesa Road**  
13 **Little Rock, CA 93543**  
**Registered Nurse License No. 536466**

**A C C U S A T I O N**

14 Respondent.

15  
16 Complainant alleges:

17 **PARTIES**

18 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her  
19 official capacity as the Interim Executive Officer of the Board of Registered Nursing (Board),  
20 Department of Consumer Affairs.

21 2. On or about September 8, 1997, the Board issued Registered Nurse License Number  
22 536466 to Deborah Anne Benner (Respondent). The Registered Nurse License was in full force  
23 and effect at all times relevant to the charges brought herein and will expire on September 30,  
24 2011, unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board under the authority of the following  
27 laws. All section references are to the Business and Professions Code (Code) unless otherwise  
28 indicated.

**STATUTORY PROVISIONS**

4. Section 2750 of the Code provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811(b) of the Code, the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

1       ....  
2       “(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any  
3 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this  
4 section.”

5       8. California Code of Regulations, title 16, section 1442, states:

6       "As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from  
7 the standard of care which, under similar circumstances, would have ordinarily been exercised by  
8 a competent registered nurse. Such an extreme departure means the repeated failure to provide  
9 nursing care as required or failure to provide care or to exercise ordinary precaution in a single  
10 situation which the nurse knew, or should have known, could have jeopardized the client's health  
11 or life."

#### 12                                   **COST RECOVERY PROVISION**

13       9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
14 administrative law judge to direct a licentiate found to have committed a violation or violations of  
15 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
16 enforcement of the case.

#### 17                                   **DRUGS DEFINITION**

18       10. **Fentanyl** is a Schedule II controlled substance pursuant to Health and Safety Code  
19 section 11055(c)(8), and is a dangerous drug pursuant to Business and Professions Code section  
20 4022.

21       11. **Methadone**, a synthetic opiate, is a Schedule II controlled substance as designated by  
22 Health and Safety Code section 11055(c)(14) and a dangerous drug according to Business and  
23 Professions Code section 4022.

24       12. **Versed**, trade name for Midazolam, is a water soluble benzodiazepine Schedule IV  
25 controlled substance as defined in Health and Safety Code section 11057(d) and a dangerous drug  
26 according to Business and Professions Code section 4022.

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ANTELOPE VALLEY HOSPITAL

13. From about March 1, 2006 to March 14, 2006, while employed as a registered nurse at the Antelope Valley Hospital, Respondent was observed by her co-workers to have exhibited a change of behavior and symptoms of under the influence. These symptoms and behavior included, but not limited to, absence and tardiness from the unit without explanation, using the restroom frequently and for a prolonged amount of time. After she exited the restroom, she was observed to have discarded syringes into the Sharps container with her eyes half closed and appeared lethargic with slurred speech. On or about March 14, 2006, Respondent was tested positive for Methadone and Fentanyl at work.

14. At all times relevant to the charges herein, Antelope Valley Hospital used a drug dispensing system called the "Pyxis System". The Pyxis is a computerized automated medication dispensing machine. The user enters a password to gain access and dispense medication from the machine. The machine records the user name, patient name, medication, dose, date and time of the withdrawal. The Pyxis is integrated with hospital pharmacy inventory management systems. An investigation of Respondent's Pyxis activities reveals the following discrepancies:

- a. Patient A. On or about February 24, 2006, Respondent withdrew 200mg Fentanyl and charted the administration of 100mg. The remaining 100mg was not wasted or returned.
- b. Patient B. On or about February 24, 2006, another nurse withdrew 6mg (3 vials) Versed and charted the administration of 4mg (2 vials). Respondent charted the return of 2mg (1 vial), and "AMT GIVEN: 1mg (AMT WASTED: 3mg)."
- c. Patient B. On or about February 24, 2006, another nurse withdrew 200mg Fentanyl and charted the administration of 200mg. Respondent charted "AMT GIVEN: 1.5 AMPULE (AMT WASTED: 0.5 AMPULE)"

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1 controlled substances and dangerous drugs. Complainant refers to and incorporates all the  
2 allegations contained in paragraph 14 above, as though set forth fully.

3 **FOURTH CAUSE FOR DISCIPLINE**

4 **(Gross Negligence)**

5 18. Respondent is subject to disciplinary action under Code section 2761, subdivision  
6 (a)(1) in conjunction with California Code of Regulations, title 16, section 1442, in that while  
7 working as a registered nurse at Antelope Valley Hospital from February 2006 to March 2006,  
8 Respondent committed gross negligence by illegally obtaining or possessing controlled  
9 substances, practicing nursing with an impaired ability, and making false, grossly incorrect or  
10 inconsistent entries of controlled substances in the hospital records. Complainant refers to and  
11 incorporates all the allegations contained in paragraphs 13 -17 above, as though set forth fully.

12 **FACTOR IN AGGRAVATION**

13 19. On or about June 2, 2006, Respondent entered into the Board's Diversion Program.  
14 On or about February 28, 2008, Respondent was terminated from the Diversion Program for  
15 failure to comply with the provisions of the contract.

16 **PRAYER**

17 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
18 and that following the hearing, the Board of Registered Nursing issue a decision:

19 1. Revoking or suspending Registered Nurse License Number 536466, issued to  
20 Deborah Anne Benner;

21 2. Ordering Deborah Anne Benner to pay the Board of Registered Nursing the  
22 reasonable costs of the investigation and enforcement of this case, pursuant to Business and  
23 Professions Code section 125.3;

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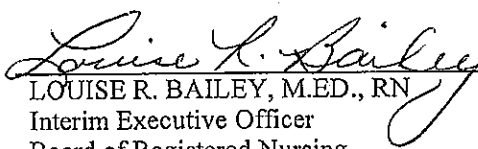
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3. Taking such other and further action as deemed necessary and proper.

DATED: 6/3/10

  
LOUISE R. BAILEY, M.ED., RN  
Interim Executive Officer  
Board of Registered Nursing  
Department of Consumer Affairs  
State of California  
*Complainant*

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